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MEMORANDUM

TO: Area Directors

FROM: Mike Moseley, Director, DMHDDSAS
Gary Fuquay, Director, DMA

SUBJECT: October – December, 2004 System Reform Issues Update

DATE: November 30, 2004

The Department of Health and Human Services remains fully committed to the effort to reform the public mh/dd/sa system. The principles upon which reform is based are the following:

- the delivery system must provide for consumer involvement in system design;
- services and supports must be tailored to meet the needs of individual consumers through person centered planning;
- the primary locus for service delivery should be in communities; and
- the way to ensure that consumers' voices are heard and that services rendered are of high quality is through a strong Local Management Entity (LME) responsible for service delivery in the local catchment area.

Outlined below is the update for the second quarter of SFY 2004-2005.

LME Readiness to Perform Utilization Review for Medicaid Services

The Request for Proposals to solicit a new vendor to perform utilization review (UR) for Medicaid-funded behavioral health services is currently posted on the DMA website. As we have indicated, LMEs will be authorized to perform UR for Medicaid services when they have demonstrated readiness to do so in a consistent manner that will meet Medicaid requirements for statewideness. DMHDDSAS and DMA have designed the process for assessing LMEs readiness. Those LMEs desiring to perform UR for Medicaid services effective July 1, 2005 will have a readiness review conducted in the third quarter of SFY 2004-2005. The process to demonstrate readiness will be as follows:

To perform utilization review, a LME must demonstrate that they meet the following requirements:

1. Provide evidence that the performance measures of the current contract are being met.
2. Provide evidence and demonstrate the ability to meet the same requirements that will be placed on the new statewide vendor. This includes, but is not limited to, usage of standardized forms, production of standard reports, etc.

DHHS will evaluate the readiness of any LME that wants to begin doing utilization review for Medicaid funded services on July 1, 2005 in the following manner:

1. LMEs interested in performing UR functions for Medicaid funded services effective July 1, 2005 will indicate their interest in writing to DMH/DD/SAS by January 31, 2005.
2. DMHDDSAS will review the Performance Agreement criteria compliance of the LME during the period July 1, 2004 through September 30, 2004 to ensure that current requirements are being met. This assessment will be completed by January 10, 2005.
3. LMEs will submit copies of resumes/applications/Curriculum Vitae on the staff that will be performing Medicaid UR functions to ensure that the personnel qualifications required of the statewide vendor are met. These documents must be submitted to DMHDDSAS by February 1, 2005.
4. DHHS will provide LMEs with copies of all of the forms and reports that ValueOptions currently uses and/or submits to DMA as part of the existing UR contract. These documents will be sent to all LMEs by December 10, 2004.
5. Using the ValueOptions forms and in accordance with any applicable ValueOptions timeframes, LMEs will perform Utilization Review on all state-funded services during the months of February and March 2005. As part of this effort, LMEs will
    a. Use the prior authorization functionality in IPRS to demonstrate the ability to record electronic prior authorizations for authorized state-funded services
    b. Prepare reports on state-funded services subject to UR during the period. These reports will be prepared in the same format and on the same timeframe as the reports prepared by ValueOptions for DMA. These reports will be submitted to DMHDDSAS by April 15, 2005.
6. DMA and DMHDDSAS will evaluate the staff credentials and the LME's performance during the two month test period in April, 2005.
7. LMEs deemed ready to perform Medicaid UR functions effective July 1, 2005 will be notified by May 1, 2005 of their approval.

Provider Endorsement

In order to comply with Medicaid regulations regarding enrollment of providers, while at the same time trying to ensure that participating providers are of high quality and are responsive to the needs of consumers and communities, we are designing a "provider endorsement" *(note: we have not yet reached agreement on terminology. We know that some folks are uncomfortable with the term "endorsement," but we continue to use it in this explanation since that is the word that has been used in previous correspondence)*procedure which will require LMEs to verify providers' qualifications prior to their enrollment in the Medicaid program. A workgroup consisting of staff from DMHDDSAS and DMA, four LME representatives and staff from the N. C. Council of Community Programs are meeting to design that process. Work is on-going, but agreement has been reached thus far that:

- Providers will be endorsed separately for each service to be performed and each physical location from which services will be delivered. A "physical location" is defined as a location where consumers live when receiving residential services; or, for non-residential services, a location under the provider's control where a consumer receives services on a daily basis (e.g. partial hospitalization program) or an office where medical records and/or staff records and offices are maintained.
- Providers will be endorsed one time for statewide enrollment for each service and physical location, by the LME in whose catchment area the service is located.
- The provider enrollment process will be standardized and consistent on a statewide basis – the same information will be required, a standardized checklist and provider agreement will be used, LMEs and providers will be required to adhere to established timeframes.
- A standardized process for terminating a provider's enrollment, for cause, will be developed. Termination for cause by any LME which results in the provider's disenrollment in Medicaid by DMA

will prohibit that provider from offering the same service, at the same physical location for any Medicaid eligible consumer.
- Provider endorsement and termination will flow through DMHDDSAS to DMA to ensure consistency and standardized application of processes.
- Provider endorsement will be for a three-year period, following which the provider must be re-endorsed.

The workgroup will meet again on December 17, 2004. When a "fleshed out" plan has been developed, it will be published for review and comment by all stakeholders. We anticipate that will occur early in the new calendar year.

State Plan Amendment for Prospective Rates

Effective July 1, 2004 (as part of our reform of the financing for services and LME administrative cost at the local level), we instituted a separate payment for system management functions performed by LMEs based upon the LME cost model and adjusted service rates, based upon SFY 2002 actual cost, to eliminate the "Area Administration" component of the service rate.

It is our intent to convert the service rates from interim rates, which are adjusted at the end of each year through the cost finding process, to a prospective rate methodology. That change, however, requires the approval of the Centers for Medicare and Medicaid Services (CMS). We have submitted a State Plan Amendment (SPA) to CMS to effect this change, and we anticipate that it will be approved retroactive to July 1, 2004. Since our SPA has not yet been approved, the rates that we are currently paying for services under the Medicaid program cannot be considered prospective rates. In the unlikely event that the SPA is not approved, it will be necessary to continue the cost finding process in SFY 2005 and each year thereafter that we do not have an approved SPA. We do not anticipate that will be necessary, but thought it only appropriate to apprise you of that possibility. We will keep you updated as conversations with CMS continue.

Service Rates

Rate setting, financial, and program staff from DMH/DD/SAS and DMA recently conducted three meetings with providers selected from the DMHDDSAS provider database to discuss proposed rates for CAP/MRDD, proposed mental health services and proposed substance abuse services. For CAP/MRDD services providers are providing cost data to model rates for Residential Supports, Home and Community Supports, and Day Supports. The data from the providers is due to DMA by December 3, 2004. Following the cost modeling, DMA and DMHDDSAS will present any rates that warrant an adjustment to the DHHS Rate Review Board for approval. Following action for the Board, we will publish the final rate schedule for the new CAP/MRDD Waiver.

Providers attending the meetings on mental health and substance abuse services raised several questions which our Divisions must answer before the providers can accurately determine the adequacy of the proposed rates. We have promised to respond to those questions by the end of November in order for the provider review process to continue. Again, following any input on changes on the rates from the provider community, DMA and DMHDDSAS will publish the final proposed rate schedule for the enhanced mental health and substance abuse rates.

Prior to finalizing the rate setting process, DMHDDSAS and DMA will also meet with representatives of LMEs to discuss any potentia l policy implications of the proposed rates.

Enhanced Service Definitions

The MH/DD/SA subcommittee of the Physician's Advisory Group (PAG) is continuing its review of the new service definitions for enhanced services. DMA and DMHDDSAS staff met with the subcommittee of the PAG in a face-to-face meeting on November 8, 2004. The meeting was very productive and we were able to respond to a number of questions. The current schedule calls for the full PAG to receive the subcommittee recommendations in a conference call in December. Assuming that no major changes are identified through

that review, the final service definition package will be available for public review and comment and submission to CMS in January, 2005.

Provider Specialty-Specific Rates for Outpatient Therapists

We understand that the proposal to change the way DHHS pays LMEs for Medicaid outpatient therapy services as communicated in the November 5, 2004 memo has caused quite a stir. Specifically, that proposal would have limited reimbursement to LME's for outpatient therapy services to the Medicaid rate paid to Behavioral Healthcare Specialty Groups. We apologize for the turmoil and for the fact that this proposal was not better understood at a much earlier date at the local level. In recognition of the legitimate issues raised by the NC Council and individual LMEs, DHHS is postponing implementation of this proposal until July 1, 2005.

DMA will, however, proceed with the direct enrollment of independent practitioners providing outpatient therapy services as previously announced. Providers who are currently contracting with LMEs – and who have the ability to directly enroll - will be required to directly enroll with Medicaid. It will not be permissible for a provider to choose to forego direct enrollment in order to continue to be reimbursed at the "LME rate." LMEs may provide billing services for those providers, if they so choose, but that billing must be at the provider's specialty rate using the provider's Medicaid provider number.

We recognize that some transition period will be necessary to allow for full direct enrollment; therefore, we will allow LMEs to continue to bill for providers who are working on direct enrollment through the end of February 2005. Beginning March 1, 2005, all providers with the ability to directly enroll in the Medicaid program must do so in order to bill for services to Medicaid eligible consumers.

We hope this information is helpful. We will publish our next update in February, 2005. We would like to take this opportunity to wish you, your families and employees a happy holiday season.

cc: Carmen Hooker Odom
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